Membership #: _____ **Medical Home:** _____

CIN#: _____ **Primary Care Provider:** _____

HEALTHY WAY LA (HWLA) ANNUAL REDETERMINATION FORM
You must fill out this form and return it to keep your HWLA

Use ink and print your answers below:

Print Your Full Name	**Social Security Number**
Last **First** **Middle**	
Current Street Address, Apartment Number	**City/State** **Zip Code**
Number **Street Name** **Apt./Unit Number**	
Mailing Address (if different from above)	**City/State** **Zip Code**

☐ **Check here if your current address or mailing address is correct, if not, please provide correct information.**

Make sure you sign and date the form. Use the enclosed envelope to return it. If you need more space, attach a separate sheet to this form. If you have any questions or need help filling out this form, **call your Medical Home at the telephone number listed on your HWLA ID CARD.**

Section 1: Health Status

Would you say that in general your/the patient's health is (circle one)?

Excellent Very Good Good Poor Fair Don't know

Section 2: Living Situation

(a) Did anyone move, into or out of your home, or did you move in with someone else (Examples: newborn, child moved out of the home)? ☐ Yes ☐ No

Name	Relationship	What Changed	Date Changed

(b) Is anyone pregnant? ☐ Yes ☐ No

If yes, who? _____

Section 3: Income

(a) Tell us what is the current source of income for any household member (example: earnings, interest, retirement, gifts, dividends, child support, disability, unemployment, alimony, Social Security, etc.)? Include income from any self-employment.

Complete boxes below and list each household member's income on a separate line.

Attach one of the following for each source (1) **current month pay stubs (month/day/yr.)** showing income before taxes or deductions, (2) benefit or award letters, (3) checks received or signed statement from employer, or (4) last year's federal income tax return. If income is from self-employment, send a copy of your most recent tax return or profit and loss statement.

Name of Person with Income	Source of Income	Income Amount	How often Paid	How many hours worked

(b) Does your household get rent, utilities, or food entirely free? ☐ Yes ☐ No

If yes, who? _____

What was free? _____

(c) Was the free rent, utilities, or food received in exchange for work done? ☐ Yes ☐ No

Section 4: Expenses and Deductions

Do you or any family member in the home pay for child or adult care, health insurance or Medicare premiums, court-ordered child support or alimony, or educational expenses? ☐ Yes ☐ No

If yes, complete below and list each expense/deduction on a separate line.

Attach proof of expenses/deductions.

Name of Person With Expense/Deduction (include first and last name)	**Type of Expense or Deduction**	**Amount of Payment**	**Paid to Whom**	**How Often Paid** *(weekly, monthly, twice a month)*

Section 5: Disability/Incapacity Changes

Do you or any family member have a physical or emotional problem during the **last 12 months** which makes it difficult to work or take care of personal needs or take care of your children? ☐ Yes ☐ No

If yes, complete the section below.

Who? _____ Explain _____

Section 6: Other Changes

Do you or any family have any other changes to report? ☐ Yes ☐ No

Explain:

I declare under penalty of perjury under the laws of California that I/the patient am not covered by Medi-Cal or Healthy Families. I certify under penalty of perjury by my signature that the information I have provided is true and complete to the best of my knowledge and belief.

I certify that during the next year, if my family size or income changes, I promise to immediately report that fact to the facility where this form was completed.

Signature	Date
Daytime or Message Telephone Number	Home Telephone Number: Cellular Number:
Signature of Witness (**If signed by a mark** or an Interpreter or a Person Assisting)	